TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STEPHEN E. EARLE, MD

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-14-2066-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MARCH 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Codes 63075 and 20930 were denied on the basis that they were 'included in another billed procedure' or 'procedure/service is not paid separately.' Per the Mutually Inclusive Table established by CMS and updated monthly, none of the codes reported for this date of service are mutually inclusive. Codes 22585-59, 63082-59, and 22585 were denied on the basis that 'the procedure/service was not documented.' Please see the attached operative report for the descriptive detail of each procedure."

Amount in Dispute: $5,040.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Stephen Earle is disputing the denial of CPT 22585 99 and 22585 59 which were denied as not documented as performed. CPT 22585 is described as an arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure). The space between two vertebral bodies is called the intervertebral space, or interspace, and contains the intervertebral disc.

The operative report, (pages 21-22 of this dispute), documents anterior interbody arthrodesis of interspaces of C4-5 and C3-4 with placement of cages. The documented anterior interbody arthrodesis of interspaces C3-4 and C4-5 were paid by CPT codes 22554 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2) and CPT 22585 (additional interspace interbody arthrodesis). Dr. Stephen Earle billed three units of 22585 and only one unit of this code was documented as performed. The 59 modifier is not supported for this reason.

Dr. Stephen Earle is disputing the denial of the second unit billed of CPT 63082 59 denied as not documented as performed. CPT 63082 is defined as Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or verve root(s); cervical, each additional segment (List separately in addition to code for primary procedure). In the body of the operative report, there were partial corpectomy documented as performed on vertebral segments C4 and C5 only. If the procedure is not documented as performed in the body of the operative report (Description of Procedures), it is not supported for payment. The partial corpectomy @ the documented segments C4 and C5 were paid by CPT 63081 and 63082.

Dr. Stephen Earle is disputing the denial of CPT 63075 defiend as Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace. CPT 63047 was denied as diskectomy procedures are included in vertebral corpectomy. Dr. Earle stated in the letter dated January 7, 2014 pages 18 and 19 (#3), of this dispute material, CPT 63075 was billed for cervical decompression and discectomy @ C3-4. According to National Correct Coding Initiative edit, CPT 63075 is global/incidental to CPT 63081/82 and should not be separately billed.

Dr. Stephen Earle is disputing the denial of CPT 20930 defined as Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure). This code was denied as this is a bundled or non covered procedure based on Medicare guidelines; no separate

payment allowed. This procedure code is a status 'B' bundled code per Medicare/CMS guidelines and is not payable as is a packaged service/item; no separate payment made."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2013	CPT Code 22585-99 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	$700.00	$0.00
	CPT Code 22585-59 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	$700.00	$0.00
	CPT Code 63082-59 Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)	$550.00	$0.00
	CPT Code 20930 Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	$550.00	$0.00
	CPT Code 63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	$2,540.00	$0.00
TOTAL		$5,040.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B12-Services not documented in patients' medical records.
   - X133-This charge was not reflected in the report as one of the procedures or services performed.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was process properly.
   - 97-Payment is included in the allowance for another service/procedure.
   - U718-Diskectomy procedures are included invertebral corpectomy.
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
   - U058-Procedure code should not be billed without appropriate primary procedure.

Issues

1. Does the documentation support billing CPT code 22585-99 and 22585-59? Is the requestor entitled to reimbursement?
2. Does the documentation support billing CPT code 63082-59? Is the requestor entitled to reimbursement?
3. Is the allowance of CPT code 63075 included in the allowance of another procedure performed on the disputed date of service? Is the requestor entitled to reimbursement?
4. Is the allowance of CPT code 20930 included in the allowance of another service/procedure billed on the disputed date of service? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of the respondent denied reimbursement for CPT code 22585-99 and 22585-59 based upon reason code "B12."

   On the disputed date of service, the requestor billed codes 22585-99, 22588-22, 22830-59, 22851-59, 63082-59, 22851, 22845, 63081, 63082, 20930, 22585-59, 63075, 20937, 22326-59, 22328, 22554 and 22585.

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Per CCI edits, CPT code 22585 is a component of 63075; however, a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor appended modifier "59" and "99" to code 22585.

   CPT code 22585 is defined as "Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)."

   Modifier 59-Distinct Procedural Service is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   Modifier 99-Multiple Modifiers is defined as "Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service."

   The requestor states in the position summary that "Please see the attached operative report for the descriptive detail of each procedure."

   The respondent contends that "The space between two vertebral bodies is called the intervertebral space, or interspace, and contains the intervertebral disc. The operative report, (pages 21-22 of this dispute), documents anterior interbody arthrodesis of interspaces of C4-5 and C3-4 with placement of cages. The documented anterior interbody arthrodesis of interspaces C3-4 and C4-5 were paid by CPT codes 22554 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2) and CPT 22585 (additional interspace interbody arthrodesis). Dr. Stephen Earle billed three units of 22585 and only one unit of this code was documented as performed. The 59 modifier is not supported for this reason."

The Operative Report indicates “Anterior arthrodesis with autograft and allograft C4-C5 and C3-C4.”

The Division finds the following regarding the billing of codes 22585-99 and 22585-59:

- The requestor billed for three units using codes 22585, 22585-59 and 22585-99.
- The documentation supports two units; however, only one unit is reimbursable because both 22585 and 63075 were performed at C3-C4. As stated above, the arthrodesis at C3-C4 is global to code 63075.
- The use of modifier “99” is not supported. As a result, no reimbursement is recommended for code 22585-99 performed at C3-C4.
- The requestor did not document the anterior arthrodesis at C7 in Operative report. As a result, no reimbursement is recommended for code 22585-59.
- The explanation of benefits, indicate that the respondent appropriately paid for one unit of code 22585 at C4-C5. As a result, additional reimbursement is not recommended.

2. According to the explanation of the respondent denied reimbursement for CPT code 63082-59 based upon reason code “B12.”

   CPT code 63082 is defined as “Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure).”

   The requestor appended modifier 59-Distinct Procedural Service to code 63082.

   CPT code 63082 is an add-on code and must be billed with the primary procedure code 63081.

   The requestor stated that “Please see the attached operative report for the descriptive detail of each procedure.”

   The respondent further explains that payment is not due because “In the body of the operative report, there were partial corpectomy documented as performed on vertebral segments C4 and C5 only. If the procedure is not documented as performed in the body of the operative report (Description of Procedures), it is not supported for payment. The partial corpectomy @ the documented segments C4 and C5 were paid by CPT 63081 and 63082.”

   The Division reviewed The Operative report and found that under the heading SURGICAL PROCEDURE(S) PERFORMED the requestor wrote “Partial corpectomy at C4, partial corpectomy at C5, partial corpectomy at C7 to affect decompression.” In the body of the Operative report under the heading DESCRIPTION OF PROCEDURE / TECHNIQUE / FINDINGS/ COMPLICATIONS, PROTHETIC DEVICES, GRAFTS, TISSUES, TRANSPLANTS, DEVICES IMPLANTED the requestor wrote “There was partial corpectomy performed at C4 and partial corpectomy performed at C5 to affect the diskectomy and neural foraminotomy.”

   The Division finds that the documentation supports partial corpectomy at C4 and C5. It does not support the additional unit of code 63082-59 for C7. As a result, no reimbursement is recommended.

3. According to the explanation of the respondent denied reimbursement for CPT code 63075 based upon reason code “97”.

   Per CCI edits, CPT code 63075 is a component of code 63081 and 63082; however, a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor did not append a modifier to code 63075; therefore, the respondent’s denial based upon reason code “97” is supported. As a result, reimbursement is not recommended.

4. According to the explanation of the respondent denied reimbursement for CPT code 20930 based upon reason code “B291”.

   Per CMS guidelines, code 20930 is a status “B-Bundled” code; therefore, it is a packaged service. As a result, separate reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		08/06/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.